PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Who seeks primary care for sleep, anxiety and depressive disorders from physicians prescribing homeopathic and other complementary medicine? Results from the EPI3 population survey.
AUTHORS	Grimaldi-Bensouda, Lamiae; Engel, Pierre; Massol, Jacques; Guillemot, Didier; Avouac, Bernard; Duru, Gerard; Lert, France; Magnier, Anne-Marie; Rossignol, Michel; Rouillon, Frederic; Abenhaim, Lucien; Begaud, Bernard

VERSION 1 - REVIEW

REVIEWER	Aslak Steinsbekk, professor Norwegian University of Science and Technology Norway
REVIEW RETURNED	16-Jul-2012

THE STUDY	Aim need to be specified more
GENERAL COMMENTS	This is an interesting study and well written article. I have no major suggestions for change, but some comments for the authors to consider. The type of study should be specified to “cross sectional” and the word “association” used to make it clear that no causal inference can be drawn. E.g. the aim in the abstract uses “determinants” which indicate a prospective design. The aim in the abstract and text is different. I would suggest rephrasing to something similar to: “Investigating the characteristics, health status, treatment and attitudes towards CAM for patients with SADD visiting…”. The abbreviation EPI3 is not written in full any place. I personally think EPI3 should be omitted and replaced with “this study”. Please include a sentence or two more about how the patients choose their GP, is there any previous data suggesting that patients select GPs based on the GPs prescribing preferences? There is no presentation of the number of GP and their characteristics. This should be included in the start of the result section. A flow chart of the patients would be helpful. I find the CONSORT guidelines for non-pharmacological trials to be relevant for showing both patient and providers. Some information about non-respondents should be given in results and mentioned in discussion.

	Much of the text in the result section is repetition of what is found in the tables, presented in a way that makes it difficult to find what the main findings are. I suggest to shorten the text by only presenting the main findings. It is not evident throughout the article that the comparison is between GP-CM and the two other groups. As there are few differences between GP-CM and GP mixed, this could be presented in a separate section and the rest of the text could then focus on the GP-CM vs GP-Homeo comparison. The Education variable should be presented in three categories (compulsory, middle level and higher education) in table 1. The references from 12 and onwards is wrongly numbered in the text, starting with line 43 on page 6. Sometimes the term “GP-allo” is used instead of “GP-CM” In table 1, line 19, page 9, there is an error (“48.pe9”). In line 40, 46 and 51 the 31 min, 12+ could be changed to >30 / >12 or over 30/12. Table 1 could include a column with p-values Page 10, line 47. Propensity should be probability (I thought first that it referred to propensity scores). The discussion is very good, the authors is complemented with good use of the literature in their discussion.

REVIEWER	Fuschia M. Sirois, PhD, BSc Canada Research Chair in Health and Well-being Professor, Department of Psychology Bishop's University Sherbrooke, Québec Canada I declare that I have no competing interests or conflicts of interest.
REVIEW RETURNED	23-Aug-2012

THE STUDY	This paper has several strengths including a large nationally representative sample size and examining the issue of the characteristics of CAM use among patients with SAAD. However, the main weakness is reflected in the title as the paper claims to answer the question of what ”drives” patients to seek care. Motivation is a difficult issue to discern using a cross-sectional, observational design. Even the term determinants assumes that the factors associated with CAM use are precursors rather than products of use. This is most problematic regarding the finding of CAM users having a healthier lifestyle, a finding that is not new and has certainly been noted by several other researchers (e.g., Nahin et al., 2007) and some which have reported that healthy behaviors may increase as a result of CAM use (e.g., Sharpe et al., 2007) or that CAM patients attribute their health behavior changes to CAM practitioners (Willams-Peiohata, et al, 2012). So the “drive” part of the research question cannot really be answered (See Sirois & Gick, 2002, Sirois & Purc-Stephenson, 2008, for more on this issue).

	Perhaps if the focus was on uncovering the profiles of people with SAAD with regards to their care-seeking choices this problem could be avoided. Then some mention could be made of the need to disentangle whether CAM promotes healthier lifestyles or if it only appeals to people with healthier lifestyles, or both (which based on the literature and health behavior change theory) is the more likely option. - The literature that is consistent with this finding should be presented and discussed: Is the healthy lifestyle a product or precursor of CAM use? Can the authors speculate on this point based on previous research in this area?
RESULTS & CONCLUSIONS	Why is there no discussion of the results of the CAMBI analyses? Even if only one subscale showed sig. differences the lack of differences is still worth noting. How do these results relate to previous findings on the health beliefs of CAM users and how does the historical context of the current findings compare to findings regarding health beliefs from previous research? Again though no conclusions can be made regarding how such belief differences between groups might "drive" care-seeking as there is compelling evidence to suggest that such beliefs change over the course of CAM treatment.

VERSION 1 – AUTHOR RESPONSE

Reviewer(s)' Comments to Author:	**Author's replies**
GENERAL COMMENTS, TITLE & ABSTRACT	
REV. #1: The type of study should be specified to "cross sectional" and the word "*association*" used to make it clear that no causal inference can be drawn. E.g. the aim in the abstract uses "*determinants*" which indicate a prospective design. **REV. #2:** The main weakness is reflected in the title as the paper claims to answer the question of what "drives" patients to seek care. The term *determinants* assumes that the factors associated with CAM use are precursors rather than products of use. Perhaps if the focus was on uncovering the profiles of people with SAAD with regards to their care-seeking choices this problem could be avoided.	We fully agree and had no intention of performing a longitudinal analysis with this cross-sectional design. Terms have been changed as suggested and the title rephrased accordingly. However, we decided to keep the verb 'seek' in the title and the text as we believe that it does not imply any directionality within analyses or interpretation of results.
REV. #1: The aim in the abstract and text is different. I would suggest rephrasing to something similar to: "Investigating the characteristics, health status, treatment and attitudes towards CAM for patients with SADD visiting…".	The objective has been standardised and rephrased so as to better reflect the cross-sectional nature of the study.
REV. #1: The abbreviation EPI3 is not written in full any place. I personally think EPI3 should be	The EPI3 abbreviation (equivalent to the name of the general study) has no other specific meaning

omitted and replaced with “this study”.	than referring to an epidemiological survey which focussed on three groups of common motives for consultation in primary care (SADD, musculoskeletal disorders and upper respiratory tract infections). We think it is important to maintain the name of the study for citation purposes (as it is often done in other large studies). No change suggested – please advise otherwise.
REV. #1: Sometimes the term “GP-allo” is used instead of “GP-CM”	Terms and abbreviations have been standardised throughout the revised manuscript.
METHODS	
REV. #1: Please include a sentence or two more about how the patients choose their GP, is there any previous data suggesting that patients select GPs based on the GPs prescribing preferences?	It was the objective of the study to better understand who consults who based on utilisation of CAMs and homeopathy, as there is no information in France on how patients select their GPs. Prescribing preferences were obtained from participating physicians at the time of their inclusion in the study therefore, except for GP-Ho who are certified homeopaths, patients did not necessarily know the differences between GP-CM and GP-Mx in terms of type of practice. No change suggested – please advise otherwise.
REV. #1: Page 10, line 47. Propensity should be probability (I thought first that it referred to propensity scores).	Change made as proposed.
RESULTS	
REV. #1: It is not evident throughout the article that the comparison is between GP-CM and the two other groups. As there are few differences between GP-CM and GP mixed, this could be presented in a separate section and the rest of the text could then focus on the GP-CM vs GP-Homeo comparison.	GP-CM group is the reference against which the other two groups are compared in all analyses. Changes have been made in the abstract, statistical methods and results (entirely revised – see below) sections to help clarify that aspect.
REV. #1: Much of the text in the result section is repetition of what is found in the tables, presented in a way that makes it difficult to find what the main findings are. I suggest to shorten the text by only presenting the main findings.	The text has been shortened with emphasis on main findings (changes have not been underlined as the whole section was shortened).
REV. #1: There is no presentation of the number of GP and their characteristics. This should be included in the start of the result section.	Information has been added to the first paragraph of results.

REV. #1: A flow chart of the patients would be helpful. I find the CONSORT guidelines for non-pharmacological trials to be relevant for showing both patient and providers.	Given this was a general survey, specific motives for non-participation were not collected. We feel that the participation rate of 73.1% was quite exceptional considering the type of health survey and that a flow chart would not contribute to further clarify potential biases (see also below). No change suggested - please advise otherwise.
REV. #1: Some information about non-respondents should be given in results and mentioned in discussion.	Information added to the first paragraph of results.
DISCUSSION	
REV. #2: Some mention could be made of the need to disentangle whether CAM promotes healthier lifestyles or if it only appeals to people with healthier lifestyles, or both (which based on the literature and health behavior change theory) is the more likely option. The literature that is consistent with this finding should be presented and discussed: Is the healthy lifestyle a product or precursor of CAM use? Can the authors speculate on this point based on previous research in this area? The "drive" part of the research question cannot really be answered (See Sirois & Gick, 2002, Sirois & Purc-Stephenson, 2008, Nahin et al. 2007, Sharpe 2007 and Willams-Peiohata 2012 for more on this issue).	We fully agree. The cross-sectional nature of this study (as in the majority of this domain) has been highlighted in the discussion (second paragraph of the discussion). We feel that the literature suggested is not directly applicable to our setting where all consultants were physicians with various degrees of preference for utilisation of homeopathy. The article cited refers mainly to types of CAM and preferences to health consultants rather than physicians. No change suggested.
REV. #2: Why is there no discussion of the results of the CAMBI analyses? Even if only one subscale showed sig. differences the lack of differences is still worth noting. How do these results relate to previous findings on the health beliefs of CAM users and how does the historical context of the current findings compare to findings regarding health beliefs from previous research? Again though no conclusions can be made regarding how such belief differences between groups might "drive" care-seeking as there is compelling evidence to suggest that such beliefs change over the course of CAM treatment.	A section has been added to the discussion to highlight CAMBI results and their potential contribution to criterion validity outside the United Kingdom where it was first tested.
TABLES	
REV. #1: The Education variable should be presented in three categories (compulsory,	In France, secondary school is compulsory (*lycée*). National statistics are dichotomised below secondary school level (compulsory

middle level and higher education) in **table 1**.	education) and secondary school completed (or above). No change suggested.
REV. #1: In **table 1**, line 19, page 9, there is an error ("48.pe9"). In line 40, 46 and 51 the 31 min, 12+ could be changed to >30 / >12 or over 30/12.	Typo removed and changes made as suggested.
REV. #1: Table 1 could include a column with p-values	As tables 1 and 2 are already quite loaded, we feel that a superscript to indicate statistical significance is sufficient. No change suggested – please advise otherwise.
REFERENCES	
REV. #1: The references from 12 and onwards is wrongly numbered in the text, starting with line 43 on page 6.	Thank you - References have been checked and renumbered.

VERSION 2 – REVIEW

REVIEWER	Fuschia Sirois, PhD Canada Research Chair in Health and Well-being Professor of Psychology Bishop's University
REVIEW RETURNED	10-Oct-2012

THE STUDY	Nahin et al., 2007; Sharpe et al., 2007; Willams-Peiohata, et al, 2012, for example, plus other research on the association of CAM use and healthy lifestyle. See comments below.
RESULTS & CONCLUSIONS	The authors have addressed the issue raised about the missing CAMBI information and the highlighted the limitations of their cross-sectional study with respect to any conclusions regarding motives for CAM use to my satisfaction. They have also attempted to address the question of why people consulting a GP-HO may have healthier lifestyles. However, in giving this reason – "..the healthier lifestyle observed among patients of - the GP-Ho group could result from a selection bias "– the authors have still not supported or linked their answer or the general finding regarding the healthier lifestyle associated with CAM use demonstrated by several; current studies as suggested previously. Selection biases can always be blamed for anomalous findings. The problem here is that this finding is not as anomalous as the authors imply by omitting reference to other relevant research on CAM use and healthy lifestyles. Their argument given for not linking their findings to other similar findings in the field regarding the association of healthy lifestyle and CAM use is not compelling for several reasons. In response to this suggestion the authors stated: We feel that the literature suggested is not directly applicable to our setting where all consultants were physicians with various degrees

	of preference for utilisation of homeopathy. The article cited refers mainly to types of CAM and preferences to health consultants rather than physicians. Physicians who are prescribing homeopathy are providing CAM treatments, are they not? Throughout the manuscript the authors make reference to how their findings related to other similar findings of CAM use in general (see “Some studies found that patients seeking CAM therapies showed more QoL impairment than patients seeking conventional therapies.[31]” for example in the discussion. The studies which have examined the links between CAM use and healthy lifestyles suggested in the previous review undoubtedly include physicians who practice Homeopathy as well as other CAM modalities, so it is not clear to me why the current findings should not be linked to the broader researcher literature on the profiles of patients who seek CAM care (whether from a GP or CAM practitioner). Linking the findings to other relevant literature helps to advance the field as a whole, while omitting these links suggests that the current findings are completely unique (or atypical) with respect to the association of CAM use and healthy lifestyles, which they are not. The focus of this paper is on the patients and their choice to seek CAM treatment. Whether or not this treatment is from a GP is not likely to change the relevance of these findings for understanding the profiles of those who seek care from practitioners of CAM, be it Homeopathy or another modality. Unless the authors can make a more compelling (and consistent) argument for not linking their findings to the larger research literature on CAM use and having a healthy lifestyle, I would strongly recommend that they better contextualize their findings by including some reference to this other work.

VERSION 2 – AUTHOR RESPONSE

Please find enclosed a second revision with new text and references added to pages 15 and 16 (second paragraph of discussion); the reference list has been revised and renumbered also. Kindly note that all changes to the previous version of our manuscript are highlighted in yellow so that they can be easily identified.